





PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered  
May 18, 2016

Ms. Michelle Mangan, Administrator  
Capitol View Transitional Care Center  
640 Jackson Street  
Saint Paul, Minnesota 55101

RE: Project Number S5534026

Dear Ms. Mangan:

On May 12, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The Federal Form CMS-2567 is being electronically delivered.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
85 East Seventh Place, Suite 220  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900  
kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Program Assurance Unit

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/12/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAPITOL VIEW TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 JACKSON STREET SAINT PAUL, MN 55101</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  Capitol View Transitional Care Center has been found to be in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5534026

Printed: 05/17/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - CAPITAL VIEW TRANSITIONAL CARE UNIT</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/12/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>CAPITOL VIEW TRANSITIONAL CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 JACKSON STREET SAINT PAUL, MN 55101</b>		
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 12, 2016, at the request of Minnesota Department of Health. At the time of this survey, Capitol View Transitional Care Center, located on the 8th floor of Regions Hospital, was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.</p> <p>This 10-story building was constructed in 1965, and was determined to be of Type I(332) construction. The building has a full basement and is fully fire sprinklered. The building has a fire alarm system, with smoke detection in spaces open to the corridor and in all resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 29 beds at the time of this survey.</p> <p>The requirement at 42 CFR, Subpart 483.70(a) is MET.</p>	K 000		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

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Electronically submitted  
May 18, 2016

Ms. Michelle Mangan, Administrator  
Capitol View Transitional Care Center  
640 Jackson Street  
Saint Paul, Minnesota 55101

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5534026

Dear Ms. Mangan:

The above facility was surveyed on May 9, 2016 through May 12, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

Capitol View Transitional Care Center

May 18, 2016

Page 2

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,



Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
85 East Seventh Place, Suite 220  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900  
kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility  
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00498</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/12/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAPITOL VIEW TRANSITIONAL CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>640 JACKSON STREET SAINT PAUL, MN 55101</b>
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: On May 9th, 10th, 11th and 12th, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and</p>	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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2 000	Continued From page 1  Certification Programs; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	<p>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p>	
2 302	<p>MN State Statute 144.6503 Alzheimer's disease or related disorder train</p> <p>ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503</p> <p>(a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care.</p>	2 302		



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2 302	<p>Continued From page 2</p> <p>(b) Areas of required training include:                      (1) an explanation of Alzheimer's disease and related disorders;                      (2) assistance with activities of daily living;                      (3) problem solving with challenging behaviors;                      and                      (4) communication skills.                      (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.                      (d) The facility shall document compliance with this section.</p> <p>This MN Requirement is not met as evidenced by:                      Based on interview and document review, the facility failed to provide to residents and/or their designated representatives a description of the training program for Alzheimer's disease and related disorders, the categories of employees trained, the frequency of training, and the basic topics covered. This had the potential to impact all 22 residents of the facility.</p> <p>Findings include:                      On 5/12/16 at 9:22 a.m. the administrator reported the facility had failed to provide to residents and/or their designated representatives a description of the training program for Alzheimer's disease and related disorders, the categories of employees trained, the frequency of training, and the basic topics covered.</p> <p>The All Staff In-Service Training policy, last</p>	2 302		

Minnesota Department of Health

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2 302	<p>Continued From page 3</p> <p>reviewed 7/14/15, directed staff on Annual Education Topics: "Alzheimer's/Dementia: an explanation of Alzheimer's disease and related disorders; assistance with activities of daily living' problem solving with challenging behaviors; and communication skills. The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered."</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a process to provide to consumers in written or electronic form a description of the Alzheimer's disease and related disorders training program, the categories of employees trained, the frequency of training and the basic topics covered. The administrator or designee could educate staff involved in this process on the new procedure.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 302		
21426	<p>MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control</p> <p>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis</p>	21426		

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21426	<p>Continued From page 4</p> <p>infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) Written compliance with this subdivision must be maintained by the nursing home.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to document complete results of the tuberculosis (TB) skin test (TST) that was given for 1 of 5 residents (R158) reviewed for TB screening. The facility failed to ensure completion of Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents for 5 of 5 residents (R17, R123, R153, R158, R163). In addition, the facility failed to document results of the TST given for 1 of 5 employees (E1) reviewed for TB screening.</p> <p>Findings include:</p> <p>R158 was admitted to the facility on 4/12/16, per R158's admission Minimum Data Set (MDS). R158's immunization record revealed R158 was given the first step TST on 4/12/16 with results read on 4/14/16. The second TST was not given. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed.</p> <p>R17 was admitted to the facility on 3/14/16, per</p>	21426		

Minnesota Department of Health

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21426	<p>Continued From page 5</p> <p>R17's admission MDS. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed.</p> <p>R123 was admitted to the facility on 3/17/16, per R123's entry MDS. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed.</p> <p>R153 was admitted to the facility on 4/1/16, per R153's admission MDS. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed.</p> <p>R163 was admitted to the facility on 5/4/16, per R163's immunization record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed.</p> <p>E1's start date was 2/25/16. The first step TST was given on 2/21/16, with results read on 2/23/16. The second step TST was not given.</p> <p>On 5/12/16, at 10:25 a.m. director of nursing (DON) confirmed they did not do symptom screening for residents, did not have symptom screening forms completed. DON also confirmed R158 did not have a 2nd step TST. At 11:00 a.m. DON further stated all new staff get initial 1st step TST before working. If they had 2 step TST recently it would be accepted. If they had proof of TST 1st step they would do 2nd step here. Everyone should have 2nd step TST. Capitol View undated policy MI20 - Tuberculosis, Screening Patients for directed "This facility shall screen all patients for tuberculosis infection and disease (TB)... b. Any patient without documented negative TST, BAMT or CXR within the previous 12 months will receive a baseline (two-step) TST or (one-step) BAMT upon</p>	21426		

Minnesota Department of Health

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21426	<p>Continued From page 6</p> <p>admission... g. Screening of new admissions or readmissions for Tuberculosis infection and disease will be in compliance with State regulations."</p> <p>Capitol View undated policy MI19 - Tuberculosis, Employee Screening for directed "All employees shall be screened for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium tuberculosis (BAMT) and symptom screening, prior to beginning employment... a. If the reaction to the first skin test is negative, the facility will administer a second skin test 1 to 2 weeks after the first test.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21426		